TALLAHASSEE MEDICAL GROUP

E. Jonathan Perry IV M.D.
Board Certified Family Practitioner
Tallahassee Medical Group
317 Norton Drive, Suite 102
Tallahassee, Fl 32308
850-402-6215

Dear New Patient,

Welcome to our practice!

All of us at Dr. Jonathan Perry's office are excited that you have chosen us to become part of your healthcare family.

Before your appointment, there are a few things that we need from you. Enclosed with this letter you will find your new patient information. Please fill out the forms and return them to the office as soon as you can. It is vital that we have this information well before your appointment so that we can be prepared to take care of you.

If you have not already done so, please request your records to be transferred to our office. If you need a records release form, you will find it enclosed at the end of this packet. Just fill it out and take or mail it to your prior doctor's office. This way we can have your past medical records before you arrive. We would also be more than happy to help you with this if you would like!

We look forward to meeting you soon! If you have any questions prior to your appointment, please feel free to contact us at 850-402-6215.

Have a wonderful day!

~Dr Jonathan Perry and Staff

E. Jonathan Perry IV, M.D.

Registration Form

First name_____ MI____ Last Name_____ Suffix____

Mailing Address _____Apt_____City_____ ST____ Zip _____

Date Of Birth_____ Social Security #_____ Gender ☐ Male ☐ Female

Home Phone_____ Cell_____ Work _____

☐ Employed Occupation _____ ☐ Not currently working ☐ Retired ☐ Disabled ☐ Student

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse/Partner Name:_____

Primary Insurance: _____ ID# _____ Group # _____

Secondary Insurance: _____ ID# _____ Group # _____

Subscriber Name: _____ Subscriber D.O.B. _____ Subscriber Social:_____

Medical History: Please check any medical conditions you have experienced in the past or are currently experiencing.

☐ Alcoholism	☐ Dementia	☐ High Blood Pressure	☐ Thyroid disease
☐ Anemia	☐ Depression	☐ High Cholesterol	☐ Other: _____
☐ Anxiety	☐ Diabetes	☐ Liver disease	_____
☐ Asthma	☐ Epilepsy	☐ Pacemaker	_____
☐ Cancer	☐ Gout	☐ Sleep Apnea	☐ Pediatric Patients: Any issues at birth?
Type:_____	☐ Heart disease	☐ STD/STI	_____
☐ COPD/Emphysema	☐ Hepatitis	☐ Stroke	_____

Social History:

Level of Education: ☐ Completed High school/GED ☐ Some College ☐ Completed AA/ BA/ MA ☐ Other_____

Faith/ Religion: _____

Exercise: ☐ Yes ☐ No How Many Times per Week? _____

Tobacco: ☐ Yes ☐ No How many packs per day? _____ For How many years? _____

Have you quit? ☐ Yes ☐ No If so, when? _____ If not, are you interested in trying? ☐ Yes ☐ No

Alcohol: ☐ Yes ☐ No How many servings per week? _____

Sexual Activity: ☐ Active ☐ Inactive

Demographics: Please note that providing the information below is completely voluntary. Simply check "Prefer not to share" for the information you do not wish to provide. Thank you for your cooperation.

Primary Language:_____ Do you need an interpreter? ☐ Yes ☐ No

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Prefer not to share

Race: ☐ Caucasian/White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More Than One Race ☐ Prefer not to share

Medications: Please list or attach a current list of all medications you are taking including prescription, over the counter and herbals/ supplements.

Alert!! Please be aware that at this time Dr. Perry is not prescribing most chronic controlled substances. These medications will be referred to an appropriate specialist. Please sign and date below that you have read and understand this statement.

Name:_____ **Date:**_____

Name of medication:	*Dose:*	*Frequency:*	*Name of medication:*	*Dose:*	*Frequency:*

Immunizations: Please check shots you have had and list the year or attach records.

☐ Pneumovax 23 _____ ☐ Prevnar 13 _____ ☐ Shingles/"Shingrix"_____

☐ Tetanus _____ ☐ Whooping Cough _____ Pediatric Patients: Up to date on shots? ☐ Yes ☐ No

Please indicate the appointment date or year of your last exam and with whom:

Annual "Physical" Exam _____ Eye Exam _____

Dental Exam _____ Colonoscopy _____

Females only:

Pap Smear _____ Mammogram _____

Bone Density _____

Allergies: Please list all medication allergies and their associated reactions.

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

Surgical History: Please list all surgeries with dates/year.

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

Family History: Please list any blood relatives with the following chronic illnesses. (Example: Diabetes: *Sister, maternal aunt*)

Alcoholism: _____ High Blood Pressure: _____

Asthma: _____ High Cholesterol: _____

Cancer: _____

Diabetes: _____ Kidney Disease: _____

Heart Disease: _____ Mental Illness: _____

Other: _____

Preferred Pharmacy

Patient Communications Instructions, Patient's Release and Acknowledgement

TALLAHASSEE MEDICAL GROUP

Patient Name (PRINT): _____

Date of Birth: _____

Patient address: _____

Please tell us what you would like to authorize or limit with this form (check all that apply):

___ I would like to UPDATE or CHANGE my telephone and/or email contact information.

___ I would like to AUTHORIZE or CHANGE MY AUTHORIZATION for certain individuals to have access to and/or receive communication and disclosures concerning my healthcare.

___ I would like to LIMIT or REVOKE my authorization for individuals that have previously had access to and/or received communication and disclosures concerning my healthcare

Which of the following communication means are appropriate/acceptable for our office to communicate with you? (Please check all that apply.)

___ Home phone number—leave a message to return call with NO particulars Phone#_____

___ Home phone number—leave a message to return call WITH particulars Phone#_____

___ Work phone number—leave a message to return call with NO particulars Phone#_____

___ Work phone number—leave a message to return call WITH particulars Phone#_____

___ Cell phone number—leave a message to return call with NO particulars Phone#_____

___ Cell phone number—leave a message to return call WITH particulars Phone#_____

___ Email _____(Please do not assume that email will be used by your physician for communication. Please talk to your physician about the use of email as a means of communication.)

___ Other (EXPLAIN AND PROVIDE DETAILS) _____

___ Other (EXPLAIN AND PROVIDE DETAILS) _____

Who are you authorizing our office to discuss your health situation with? (Please list all names)

___ Discuss with no one

___ Spouse: Circle AUTHORIZED or UNAUTHORIZED (Name:_____)

___ Child: Circle AUTHORIZED or UNAUTHORIZED (Name:_____)

___ Sibling: Circle AUTHORIZED or UNAUTHORIZED (Name:_____)

___ Other: Circle AUTHORIZED or UNAUTHORIZED (Name:_____)

___ Other: Circle AUTHORIZED or UNAUTHORIZED (Name:_____)

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name: _____ Relationship: _____ Phone:_____

This authorization will expire on: _____(If no date is specified, it will expire upon your written amendment and instructions through your execution of a change to the information contained on this form via a completion of a new/replacement form).

By signing below, I acknowledge that I have received and reviewed a copy of Tallahassee Primary Care Associates' Notice of Privacy Policies.

_____ _____

Signature of Patient or Legal Guardian **Date**

If not the patient, explain relationship and legal authority:_____

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

Consent for Services of a Minor Child

In almost all cases, Tallahassee Medical Group (TMG) requires written consent from a parent(s) or legal guardian(s) in order to provide healthcare services at physician's offices for a minor child under the age of 18.

All parent(s) or guardian(s) are encouraged to attend all medical appointments at Tallahassee Medical Group, but we understand that isn't always possible. To avoid having to reschedule appointments when a parent(s) or guardian(s) is unable to attend, this consent form authorizing TMG and its medical professional to provide medical care must be signed by the appropriate person.

I, (We) _____ and _____ do hereby state that I am (we are) the parents or legal guardians of (child's name) _____, of minor age born on _____.

Please Initial options below*

_____ (I) We authorize and consent to all professional services provided at or arranged within the primary care office and their ancillary department(s).

_____ (I) We authorize and consent to any medically necessary treatment within the primary care office only and not ancillary department(s).

_____ (I) We do not give consent for _____(list specific test/services) services.

The below adults are authorized to seek medical care and/or ancillary services in place of the minor child's parent and/or legal guardian.

Name: _____ Relationship to minor: _____

Name: _____ Relationship to minor: _____

Name: _____ Relationship to minor: _____

Name: _____ Relationship to minor: _____

Consent expires on: _____ *(If not dated, then it will expire one year from signed date)*

Patient name:

Print: _____ **Signature:** _____

Parent/legal guardian name (*if patient is of minor age*):

Print: _____ **Signature:** _____

Date: _____/_____/_____ **Explain your relationship to patient:** _____

Tallahassee Medical Group (TMG) does not discriminate on the basis of race, color, national origin, sex, age or disability in its health programs or activities.

Tallahassee Medical Group

Financial Policy

•**Payment is due at time of service**: We accept cash, check, or credit card for payment of our estimate of your patient responsibility at the time of service. We make every effort to identify in advance of your scheduled visit all amounts that are owed or will be owed as your portion of responsibility, including deductibles, co-pays, and co-insurances. Insurers however ultimately reserve the right to process our claims and notify us of their final determination of your individual responsibility through the claims filing process. Our initial determination of your portion of financial responsibility prior to your scheduled service is therefore strictly preliminary and may be subject to adjustment when claims are actually processed by the insurer. We will of course notify you via our patient statements as soon as possible if there are changes to your financial responsibility that have occurred during claims filing based on your insurer's final determination. If requested, an itemized listing of services provided will be given to you.

• **PATIENTS WITH HIGH DEDUCTIBLE HEALTH PLANS AND PRIVATE PAY PATIENTS: Please be prepared to pay your full charges prior to service. We reserve the right to reschedule or delay service if you are unable to make payment in full at the time of service.**

• **Our Billing Services**: We will file charges on your behalf with most health plans. We are participating providers for most insurers in Tallahassee, but not all insurers – please refer to our web site for a listing of our participation agreements with health plans. It is always a good idea to confirm your health plan information with your physician's office at the time of scheduling to ensure that there have been no changes in your coverage that might impact the filing and payment of your claims. PLEASE NOTE THAT TMG IS UNABLE TO BILL OR RECEIVE PAYMENT FROM ANY H.M.O. PLANS UNLESS WE HAVE A SPECIFIC PARTICIPATION AGREEMENT WITH THE H.M.O. WE WILL BE UNABLE TO PROVIDE SERVICES TO YOU IF WE DO NOT HAVE A PARTICIPATION AGREEMENT WITH YOUR H.M.O.

• **Co-Pays, Deductibles, and Co-Insurances**: Your share of co-pays, deductibles, and co-insurance are your responsibility, and payment is due at the time of service. The portions of our charges that are your responsibility are based on your contract with your insurer, and are your part of your contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility under your contract. We are not permitted to waive or otherwise reduce this obligation on your behalf.

• **Secondary Insurances**: If applicable, secondary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any secondary coverage that you have at the time of your appointment.

• **Tertiary Insurance, if applicable:** Tertiary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any tertiary coverage that you have at the time of your appointment.

• **Charges for failing to come to your appointment (generally termed "no-show fees"):** A **$25.00** fee will apply if you fail to present to an appointment without notifying us at least 24 hours in advance.

.**Statements:** We provide patient statements to our patients every month. The statements summarize the outstanding charges and claims activity. We expect payment of your statement balance in full upon your receipt of the statement. If you have a question, if you believe there is a mistake on your statement, or if you have any concern about your statement transactions, please contact us in a timely manner We reserve the right to avoid the cost of sending statements to patients who have a small balance outstanding (usually less than $5.00). Our front staff will collect the balance at your next appointment.

• **Financial Promissory Form:** If you are unable to make payment in full for your portion of financial responsibility at the time of service, you will be required to sign a Financial Promissory Agreement giving you 14 calendar days to submit payment in full. **If you do not make payment within 14 calendar days, we will assess an additional $25.00 administrative fee to the original copay, deductible, or coinsurance that is due.**

• **Collections:** If no payment is received within 90 days, your account is considered delinquent and may be referred to an outside collection agency. ***Referral to outside collections may damage your credit, so we strongly urge you to contact our office to work out payment arrangements so that we can avoid this.***

*If you have any questions or concerns about our Financial Policy procedures or fees your physician's office or our billing department can help.

My signature below certifies that I have read, understand and agree to the terms of this Financial Policy.

Patient Name (Please Print): _____ Patient DOB_____/_____/_____

Patient Signature: _____

Patient Authorization for Release of Protected Health Information and Medical Records

Patient's Name _____
(Last, First, Middle/Maiden)
Patient's Address: _____ **City** _____ **State** ____ **Zip**_____
Date of Birth _____ Phone Numbers_____

I authorize my physician and/or administrative and clinical staff at Tallahassee Primary Care Associates or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

Person or Entity to Receive Information:	**Person or Entity to Disclose Information:**
Name/Organization: **Dr Jonathan Perry IV**	Name/Organization: _____
Address: 317 Norton Drive, Suite 102	Address: _____
City, State, Zip: Tallahassee, Fl. 32308	City, State, Zip: _____
Phone: (850)402-6215 Fax: (850)894-6768	Phone: _____ Fax: _____

SPECIFIC INFORMATION TO BE DISCLOSED (check all that apply):

__ Complete Medical Record
__ Lab Reports
__ Obstetrical (OB) Records
__ Billing Records
__ Surgery Records
__ Pap smear / Biopsy Reports
__ Office Notes
__ Mammogram Reports
__ other (specify): _____
__ Ultrasound Reports

DATES OF SERVICE:
_____

PURPOSE: ___ Changing Physicians, ___ Personal Copy to Patient, ___ Attorney, ___ Insurance, ___ Workers' Comp. ___ Other_____
This authorization will expire on: _____ (If no date is specified, it will expire 60 days after date signed).

CHECK AND INITIAL BELOW:

___**I DO** ___ **I DO NOT** authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions**, and all medical records and clinical information relating thereto.

*Initials of individual giving authorization:*_____

___**I DO** ___ **I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions**.

Initials of individual giving authorization: _____

___**I DO** ___**I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/or **alcohol-related** treatment.

*Initials of individual giving authorization.*_____

I have read and understand the nature of this authorization and I have been provided a copy of TMG's Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at ***Tallahassee Medical Group, 1511 Surgeons Dr, Tallahassee, Florida 32308.*** I understand that a revocation is not effective to the extent that my physician or Tallahassee Medical Group has taken action in reliance upon this authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I also understand that such revocation does not affect TMG's right to use or disclose any information as otherwise provided for in the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

_____ _____

Signature of Patient or Patient's Representative: **Date:**

_____ _____

Relationship to Patient (If applicable, attach document of guardianship or Power of Attorney) Witness:

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